National Patient Safety Agency

Concise Investigation Report Template – Summary Guidance

The following format and headings are designed to improve the recording and standardisation of information in investigation reports (including multi-incident investigations), and to facilitate collection and learning from findings. These headings will continue to be evaluated and developed over time.

Write your investigation report in the blank template which accompanies this guidance

1. Refer to quick ref. guidance here in green below as you go.
2. For detailed guidance refer to the NPSA's 'RCA investigation report writing guidance' document

[Add trust logo]

Root Cause Analysis Investigation Report

Incident description and consequences
Incident description:
Concise description of the incident.
Example only A lady with asthma sustained brain damage following IV administration of a drug to which she was known to be allergic.
Incident date:
Incident type:
Specialty:
Actual effect on patient:
Actual severity of the incident:
Level of investigation
Level 1 - Concise Investigation
Involvement and support of patient and relatives
e.g. Meetings to discuss questions the patient anticipates the investigation will address and to hear their recollection of events (anonymised in line with the patient / relatives wishes).
e.g. Family liaison person appointed, information given on sources of independent support.
FINDINGS:-
Detection of incident
Note the point in the patient's treatment AND the method by which the incident was identified. See NPSA 'Detection Factors' tool for a list of options. www.npsa.nhs.uk/rca
Care and service delivery problems
A themed list or description of the *key* problem points, expressed as care and service problems, (example here in green).
Example only (please delete and add your own findings)
Nurses on the short stay ward routinely failed to complete the section in the patient notes to highlight the existence of known allergies
Contributory factors

List or describe significant contributory factors. See the NPSA 'CF Classification Framework' tool for list of options. www.npsa.nhs.uk/rca (The Contributory Factors Grid could be used in the report or appendix as an alternative to 'Fishbone diagrams', as appropriate to the case.) Include narrative on deliberation as appropriate.
These may ultimately be termed 'associated factors' in Mental Health cases, where lessons learned rather than root causes are identified.
Example only (please delete and use your own findings)
Over years numerous assessments for nutrition, pressure ulcers, falls risk etc. had been added, causing short stay wards to see the completion of all documentation as impossible.
Root causes
These are the most fundamental underlying Contributory Factors that led to the incident. They should be addressed or escalated. Root causes should be meaningful, (not sound bites such as communication failure) and there should be a clear link (by analysis) between the root CAUSE and the EFFECT on the patient. Include narrative on deliberation / rationalisation involved in arriving at these.
Example only (please delete and use your own findings)
1. When adding or updating patient assessments & care plans, risk assessment of the wider implications of their use should be conducted and acted upon to reduce the risk of impact on patient safety
Lessons learned
Key safety and practice issues identified which may not have directly contributed to this incident but are significant and will be useful learning for others.
Example only (please delete and add your own findings)
1. A distinction should be made between essential and desirable documentation in clinical records
CONCLUSIONS:
Recommendations
Recommendations should numbered and referenced and be directly linked to root causes and lessons learned. They should be clear but not detailed (detail belongs in the action plan). To focus effective action it is generally agreed that recommendations should be kept to a minimum where ever possible.
Examples below (please delete and use your own findings)
1. Ensure allergy records and other priority assessment sheets are routinely filed prominently.
2. Ensure essential assessment criteria are set as mandatory fields in new electronic record development
Arrangements for Shared Learning
Describe how learning has been or will be shared with staff and other organisations (e.g. through bulletins, PSAT/Regional offices, professional networks, Reporting to NPSA, etc.)
Examples only below (please delete and add your own findings)
• Share findings with other departments caring for short stay patoents & include them in piloting solutions.
• Share findings with NPSA, SHA & PCT to identify opportunities for sharing outside the organisation.
Author and Job title
Add text
Report date
Add text

Chronology (timeline) of events	
Date & Time	**Event**

With Action plan, see also 'Types of Preventative Actions Planned'- tool at www.npsa.nhs.uk/rca

Action Plan	Action 1	Action 2	Action 3
Root CAUSE			
EFFECT on Patient			
Recommendation			
Action to Address Root Cause			
Level for Action (Org, Direct, Team)			
Implementation by:			
Target Date for Implementation			
Additional Resources Required (Time, money, other)			
Evidence of Progress and Completion			
Monitoring & Evaluation Arrangements			
Sign off - action completed date:			
Sign off by:			